CENTERS FO	R MEDICARE & MEDIC					ON	VIB NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	CONSTRUCTION	(X3) DATE	ESURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLETED	
		155077				09/16/2	2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	R					
			45 BEACHWAY DRIVE				
LAKEVIE	EW MANOR INC		INDIANAPOLIS, IN46224				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR	E	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	MAIE	DATE
F0000							
1 0000							
	This visit was fo	or Investigation of	FO	0000	Submission of this plan of		1
		•	10	7000	correction does not consiti	tute	
	1 ^	0094814, IN00095455,			admission or agreement by	√ the	
	IN00096396 and	d IN00096640.			provider of the truth of fact		
					alleged or correction set fo		
	Complaint Num	bers:			the statement of deficienci	es.This	
	IN00094814 - St				plan of correction is prepar	ed and	
		ficiencies related to the			submitted because of		
					requirements under state a		
	~	ited at F223, F225, F226,			federa law.Please accept t		
	F309.				plan of correction as our cr	edible	
					allegation of compliance		
	IN00095455 - St	ubstantiated.					
		ficiencies related to the					
	allegations are c	ited at F282, F312.					
	IN00096396 - S	Substantiated					
		ficiencies related to the					
	1 -	ited at F157, F223, F225,					
	F226, F282, F31	12.					
	IN100006640 S	Substantiated					
	IN00096640 - S	·					
		ficiencies related to the					
	allegations is cit	red at F323					
	Unrelated defici	encies cited.					
	Survey dates:						
	1 *	13, 14 & 16, 2011					
	September 6, 9,	13, 14 & 10, 2011					
	 Facility Number	·· 000032					
	Provider Number						
	Aim Number: 1	002/3330					
i	1		1		1		1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000032

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMP 09/16/2	LETED			
	PROVIDER OR SUPPLIEF	.	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DRIVE INDIANAPOLIS, IN46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	Survey Team: Mary Jane G. Fi	scher, RN PHNS TC						
	findings cited in 16.2.	mple: 2 es also reflect State accordance with 410 IAC						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077			(X2) MUL A. BUILD B. WING		00	(X3) DATE S COMPL 09/16/2	ETED
	PROVIDER OR SUPPLIER			45 BEAC	DDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE APOLIS, IN46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0157 SS=D	A facility must immoresident; consult wand if known, notifice representative or a when there is an a resident which respotential for requiring significant changemental, or psychosocial statuconditions or clinical alter treatment significant changemental, or psychosocial statuconditions or clinical ter treatment significant changement and significant change in resident and, if known as specified. The facility must a resident and, if known considers and in resident and if known as specified state law or regular paragraph (b)(1) of the facility must resident and the address resident's legal regramily member. Based on recording facility failed to condition, the number noted a condition, the number noted a condition, the number sident's legal regramment as specifications.	nediately inform the with the resident's physician; by the resident's legal an interested family member accident involving the ults in injury and has the ing physician intervention; a in the resident's physical, social status (i.e., a alth, mental, or as in either life threatening cal complications); a need to inficantly (i.e., a need to sting form of treatment due quences, or to commence a ment); or a decision to ge the resident from the d in §483.12(a). Ilso promptly notify the pown, the resident's legal interested family member arange in room or roommate pecified in §483.15(e)(2); or ent rights under Federal or ations as specified in	F01:		1. The physician of Resider was notified of medical concountry of the control of	erns. t ng ation	10/07/2011
	possible interven residents reviewe				appropriate follow up to familiconcerns and appropriate	ly	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155077	B. WIN			09/16/2	011
		l .	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF PROVIDER OR SUPPLIER					CHWAY DRIVE		
LAKEVIE	EW MANOR INC				APOLIS, IN46224		
(X4) ID	I SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	notification in th			-	physician notification.2. As a	all	
	1	ie sample of 10.			residents have the potential		
	[Resident "F"].				affected, Nurse's Notes for t		
					last 30 days for all residents	were	
	Findings include	»:			reviewed as well as records		
					residents re-admitted within		
	The record for R	esident "F" was reviewed			last 30 days in an effort to ide	-	
	on 09-08-11 at 2	:35 p.m. Diagnoses			any concern(s) with physicia notification and/or family	n	
	1	re not limited to cerebral			concerns requiring follow up,	and	
	vascular acciden	t, hypertension, and			corrective action taken, as	-	
		s. These diagnoses			warranted.3. Licensed nursi	ng	
		t at the time of the			staff have been re-educated		
		t at the time of the			The Physician/Family Notific	ation	
	review.				policy and procedure (see		
					attachment A) and the	otion	
	The resident had	been readmitted to the			Emergency Physician Notific procedure (see attachment		
	facility after a br	rief hospitalization for a			Nurses have also been	b).	
	change in condit	ion while visiting a			addressed in regard to respo	nse	
	family member.	The hospital			to family care concerns, inclu		
	1 -	charge summary, dated			resident assessment and	-	
	1	ted the resident had a			notification of appropriate		
	1	ant for recent embolic			supervisor(s) as to family		
	1				concerns. In this manner,		
	1 -	ascular accident] with			necessary investigation and interventions can be		
		d weakness after left			implemented, as warranted.	In	
	femoral neck fra	cture and repair.			an effort to ensure ongoing		
	Worrisome is the	e fact that [resident] has			compliance with timely physi	cian	
	been dropping th	nings from right hand and			and/or family notification, the	:	
	leaning to the rig	ght more. Patient should			DON or her designee will rev		
	1 '	pital if temperature			24-Hour Condition Reports a	ind	
	1	[Fahrenheit] or if			Nurse's Notes daily, on		
		d mental status, or			scheduled days of work, to ensure timely notification is r	nado	
	syncopal episode	-			with change(s) in condition (s		
	syncopai episode	es occur.			attachment C). Should cond		
	D : 04				be noted, immediate correcti		
		urses notes, dated			action shall be taken		
		p.m. [Friday], indicated			accordingly.4. As a means of		
	the following:				quality assurance, the finding	gs of	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	155077	A. BUI	LDING	00	COMPL 09/16/2	
		133077	B. WIN			09/10/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE		
LAKEVIE	W MANOR INC			1	APOLIS, IN46224		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	"Resident [family	y member] has			the above audits and any		
	complaints about	t care resident is			corrective actions taken will I	pe	
	receiving, states	[resident] is not being fed			reviewed during the facility's quarterly Quality Assurance		
	and turned like [1	resident] should, states			meetings and the plan of act	ion	
	[resident] has spo	oke with [name of Unit			revised, if warranted.5. The		
	Manager License	ed Practical Nurse			above corrective measures v		
	employee #2] an	d [name of Assistant			completed on or before Octo 7, 2011.	per	
	Administrator en	nployee #12] and feels no			1, 2011.		
	one is paying atto	ention to concerns.					
	[Family member] also states that					
	[resident] mental	status is decreasing, was					
	notified about lal	b. [laboratory] and x-ray					
	results, has quest	ions about thyroid labs					
	and stents to righ	nt brain feels as if					
	[resident] is hem	morhagging <sic> again.</sic>					
	physician faxed	[facsimile]. Will pass					
	on."						
	The next nurses i	note entry, dated					
	08-01-11 at 11:10	0 p.m., indicated					
	"Received a phys	sician order which					
	indicated "TSH [thyroid stimulating					
	hormone] - hypo	thyroidism."					
		iew on 09-13-11 at 8:30					
	-	nt Director of Nurses					
		icated the laboratory					
	_	een completed and she					
	_	urse practitioner on					
		Assistant Director of					
		"since there was no					
	_	ler must have been a					
	mistake."						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUII		ONSTRUCTION 00	COMPLE	TED	
		155077	B. WIN		·	09/16/20	11	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
LAKEVIE	W MANOR INC		45 BEACHWAY DRIVE INDIANAPOLIS, IN46224					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
	The record lacke	-						
		r follow up by the						
	nursing staff rela	noted on 07-29-11 to the						
	resident's physici							
	resident's physici	tan.						
	Review of facilit	y policy on 09-13-11 at						
	12:40 p.m. at 12:	J 1 J						
	"PHYSICIAN &	•						
	NOTIFICATION	PROCEDURE," dated						
	01-06, indicated							
		-						
	"PURPOSE: To	keep the physician,						
	resident and fami	ily appraised of all						
	condition change	es."						
	"PROCEDURE:							
	•	Telephone notification						
	•	l emergencies or all						
	condition change	•						
	-	nse. 2. Notify the						
		change in condition that						
		varrant a change in the						
	treatment plan [u	inderscored].						
	"Faxing: 1	Document information to						
	-	and in black ink on a fax						
	form that include							
		Include all assessment						
	-	the physician will need to						
		ns. 2. If immediate						
		se is required DO NOT						
		ysician [underscored]."						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155077	B. WING			09/16/20	011
		<u></u>	F		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L		45 BEA	CHWAY DRIVE		
	W MANOR INC				APOLIS, IN46224		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	COMPLETION DATE
IAG	This federal defic		+	IAG			DATE
		•					
	Complaint IN000	090390.					
	3.1-5(a)(2)						
	,						
F0223		the right to be free from		İ			
SS=D		ysical, and mental abuse,					
	corporal punishme seclusion.	ent, and involuntary					
	3001031011.						
	The facility must n	ot use verbal, mental,					
	sexual, or physica						
		oluntary seclusion.	FO	223	1. (a) The involved employed		10/07/2011
		ew and record review, the	FU	223	was addressed as to failure t		10/07/2011
	•	ensure residents were free			communicate a resident		
		e and potential physical			allegation. The nurse did not		
		residents reviewed for			believe the resident to be		
	abuse in the samp	ple of 10.			reporting as an "allegation of abuse"; however, the nurse h		
	Residents I and A	A			been advised to report all statements/allegations to allo administrative staff to investig	ow	
	Findings include	:			and take corrective actions accordingly. (b) Resident I's		
	1. The record fo	r Resident "I" was			allegation was reported to IS	DH	
		13-11 at 9:55 a.m.			as a reportable/unusual occurrence and investigated		
		led but were not limited			thoroughly, according to facil	ity	
		sease, hypothyroidism,			policy upon administrative		
		isorder. These diagnoses			notification of the same. (c)li		
	•	t at the time of the record			regard to the concern of Res A, the DON has been addres		
	review.				as to thorough investigation		
					allegation, including but not		
	During an intervi	iew on 09-13-11 at 9:30			limited to, interview of various	S	
	-	t indicated "over the			shifts and other potentially	۸٬۵	
	· · · · · · · · · · · · · · · · · · ·	ted to the night nurse			affected residents. Resident responsible party was contact		
	weekend rieport	or to the hight hurse			by the Director of Nursing		

STATEMENT O AND PLAN OF (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077	(X2) MULT A. BUILDI B. WING	FIPLE CONS	00	(X3) DATE S COMPL 09/16/2	ETED
	VIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DRIVE INDIANAPOLIS, IN46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
the end of	that the aide [Ceremployee #29] was to the bathroome to do it myster in the told me she had an er I couldn't and the told me she had an er I couldn't and the told me she had alter I couldn't and the told me she had alter I couldn't and the told me she had alter I couldn't it is the told the ome to talk to much a conference of the result of the told the told me to talk to much a conference of the result of the told	ral Nurse employee #28], tified Nurse Aide rouldn't help me get up to m. She told me I would elf because she couldn't 'bad back.' When I told I that I wasn't supposed to rad a 95 year old ro could take care of the worse I have been Parkinson's and I don't rry to get up on my own - nurse but no one else has re about it." on 09-13-11 at 10:40 strator and Assistant dicated they were resident's allegation. r Resident "A" was 19-11 at 9:45 a.m. red but were not limited ret failure, diabetes rusion, atrial fibrillation, risease and acute renal ruse diagnoses remained re of the record review. reses notes, dated review are reciving <sic> here</sic>			regarding follow-up to the investigation of the incident referenced in the citation.2. A residents have the potential that affected, Social Services conducted interviews of all interviewable residents to enany concerns related to staff treatment of residents were identified, communicated to administrative staff and investigated as per facility policy.3. As a means to ensure ongoing compliance with ensure residents are free from verbal potential physical abuse, staff have been re-educated on at (see attachment D) and the facility Abuse policy (see attachment E). The Director Social Services or her design will interview 5 random interviewable residents week 4 weeks, then 10 residents per month for 3 months, then quarterly thereafter to ensure further issues are identified (seattachment F) and corrective action initiated should non-compliance with ensuring residents are free from verbal and/or potential physical abuse noted.4. As a means of quality assurance, the finding the above audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of activity actions taken will be reviewed/revised, if warranted.5. The above corrective measures will be	o be sure ure suring l and ff ouse, of nee er er en see e	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155077		(X2) MI A. BUII B. WIN	LDING G	NSTRUCTION 00	(X3) DATE COMPL	ETED		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DRIVE INDIANAPOLIS, IN46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
	ankle and knee very physician] was hat resident's leg a right tib [tibia] / Spoke with POA notify about x-ray condition. POA notified as soon x-ray. I put a not labs being called in bed. Tylenol 2:00 p.m. Still at come and lab research Review of the x-08-05-11, indicating the ankle - diagonal tresident of the x-During interview a.m., the resident "[resident' name big. The ankle very [resident] leg. [Review of the x-10 tibile to	stated she wanted to be as lab came in from te to the next nurse about to POA. Res. is in room given at 10:00 a.m. and at wating <sic> x-ray to sults."</sic>			completed on or before Oct. 7, 2011.6. Please see atta-addendum.			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M A. BUII		ONSTRUCTION 00	(X3) DATE S	
		155077	B. WIN			09/16/20	011
NAME OF F	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	CHWAY DRIVE		
	W MANOR INC				APOLIS, IN46224		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
	a.m., the Director	r of Nurses indicated "I					
	l '	dent] ankle. I went down					
	_	n and [resident] said it					
	happened either	on night shift or when the					
	day shift came in	. [Resident] said the					
	-	dent]. I interviewed three					
		it no one knew anything."					
	1 1	interviews included not					
		out day shift as well, the					
		es indicated, "no." When her residents were					
		Director of Nurses stated,					
	"no."	Director of ivarses stated,					
	110.						
	4. Review of fac	ility policy on 09-08-11					
	at 1:10 p.m., title						
	PROHIBITION,	REPORTING AND					
	INVESTIGATIO	N POLICY AND					
	PROCEDURE,"	and dated 01-06					
	indicated the foll	owing:					
	· ·	will not permit residents					
	1	abuse by anyone,					
	"	yees, other residents,					
		nteers, staff or personnel serving the resident,					
	family members,						
	*	or other individuals."					
	-F						
	"4. Physical abu	se - resident to resident					
		s in injury, staff to					
		ith or without injury,					
	other (visitor, rel	ative) to resident abuse					
	with injury."						

l	OF OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMP 09/16/ 2	LETED		
	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DRIVE INDIANAPOLIS, IN46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
	and/or gestured disparaging and residents. Staff traumatic episod verbal threats the resident."	episodes of oral, written language that includes derogatory remarks to to resident - a single e, resident to resident at cause distress to a ciency relates to 0094814 and IN00096396.						

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
THIBTEIN	or condition	155077	A. BUILDING B. WING		09/16/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER		l	CHWAY DRIVE	
LAKEVIE	W MANOR INC		INDIAN	APOLIS, IN46224	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		· · · · · · · · · · · · · · · · · · ·	TAG	DEFICIENCT)	DATE
F0225 SS=D	have been found gor mistreating residence had a finding nurse aide registry mistreatment of residence of their property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities. The facility must eviolations involving abuse, including ir and misappropriating reported immediate.	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or a entered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an avould indicate unfitness for aide or other facility staff to de registry or licensing an insure that all alleged guistreatment, neglect, or njuries of unknown source ion of resident property are ely to the administrator of other officials in accordance			
	with State law thro (including to the Stagency). The facility must halleged violations a	augh established procedures tate survey and certification ave evidence that all are thoroughly investigated, further potential abuse while			
	The results of all ir reported to the addrepresentative and accordance with S State survey and ownking days of the violation is verified action must be tak Based on record facility failed to a allegations of abdadministrator and	nvestigations must be ministrator or his designated it to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective	F0225	(a)The involved employed addressed as to failure to communicate a resident allegation. The nurse did not believe the resident to be reporting as an "allegation of	:

li '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL		
		155077	B. WIN	IG		09/16/2	011	
NAME OF	PROVIDER OR SUPPLIER	2		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	I KOVIDEK OK SOI I EIEI			45 BEACHWAY DRIVE				
LAKEVIE	EW MANOR INC			INDIANAPOLIS, IN46224				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	•	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
	residents to ensu	re an allegation of			abuse"; however, the nurse I	nas		
	physical abuse w	vas thoroughly			been advised to report all statements/allegations to allo	214/		
	investigated.				administrative staff to investi			
					and take corrective actions	guio		
	This deficient pr	ractice effected 2 of 10			accordingly. (b) Resident I's			
	1	ts. [Residents "I" and			allegation was reported to IS	DH		
	"A"].	is. [1105140115 1 with			as a reportable/unusual			
					occurrence and investigated			
	Findings in alada				thoroughly, according to faci policy upon administrative	lity		
	Findings include: 1. The record for Resident "I" was				notification of the same. (c) I	n		
					regard to the concern of Res			
					A, the DON has been addres			
	reviewed on 09-13-11 at 9:55 a.m. Diagnoses included but were not limited				as to thorough investigation	of an		
					allegation, including but not			
	to Parkinson's di	sease, hypothyroidism,			limited to, interview of variou	S		
	and depressive d	lisorder. These diagnoses			shifts and other potentially affected residents. Resident	Δ'ς		
	remained curren	t at the time of the record			responsible party was contact			
	review.				by the Director of Nursing			
					regarding follow-up to the			
	During an interv	riew on 09-13-11 at 9:30			investigation of the incident			
	"	t indicated "over the			referenced in the citation.2. residents have the potential			
	1 1	ted to the night nurse			affected, Social Services	io be		
	1	cal Nurse employee #28],			conducted interviews of all			
	°	ertified Nurse Aide			interviewable residents to en	sure		
	-	wouldn't help me get up to			any concerns related to staff			
	1				treatment of residents were			
	~	om. She told me I would			identified, communicated to administrative staff and			
	1	self because she couldn't			investigated as per facility			
	1	a 'bad back.' When I told			policy.3. As a means to ens	ure		
		d that I wasn't supposed to			ongoing compliance with ens	•		
	1	had a 95 year old			residents are free from verba			
	~	o could take care of			potential physical abuse, sta have been re-educated on a			
	herself. This is t	the worse I have been			(see attachment D) and the	vus c ,		
	talked to. I have	Parkinson's and I don't			facility Abuse policy (see			
	walk and I don't	try to get up on my own -			attachment E) including repo	orting		
	I can't. I told the	e nurse but no one else has			allegations immediately to th	е		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DRIVE INDIANAPOLIS, IN46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (X5)	
NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DRIVE INDIANAPOLIS, IN46224 (X5)	
NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (X5)	
LAKEVIEW MANOR INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (X5)	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (X5)	
PROVIDER'S PLAN OF CORRECTION	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETI	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	
come to talk to me about it." administrator and administration	
conducting of a thorough	
During interview on 09-13-11 at 10:40 investigation. The Director of Social Services or her designee	
Social Services or her designee a.m., the Administrator and Assistant Social Services or her designee will interview 5 random	
Administrator indicated they were interviewable residents weekly for	
unaware of the resident's allegation. 4 weeks, then 10 residents per	
month for 3 months, then	
quarterly thereafter to ensure any further issues are identified (see	
reviewed on 09-09-11 at 9:45 a.m. attachment F) and corrective	
Diagnoses included but were not limited action initiated should	
to congestive heart failure, diabetes non-compliance with ensuring	
mellitus, hypertension, atrial fibrillation, residents are free from verbal and/or potential physical abuse	
coronary artery disease and acute renal be noted.4. As a means of	
insufficiency. These diagnoses remained quality assurance, the findings of	
current at the time of the record review.	
corrective actions taken will be reviewed during the facility's	
Review of the nurses notes, dated quarterly Quality Assurance	
08-05-11 at 10:00 a muindicated the meetings and the plan of action	
following: will be reviewed/revised, if	
warranted.5. The above corrective measures will be	
"Res. [resident] was reciving <sic> here completed on or before October</sic>	
<sic> medication and stated that her right 7, 2011.6. Please see attached</sic>	
ankle and knee was soar <sic>. [Name of addendum.</sic>	
physician] was here at the time, he looked	
at resident's leg and ordered a x-ray for	
right tib [tibia] / fib. [fibula] and ankle.	
spoke with POA [power of attorney] to	
notify about x-ray and resident's	
condition. POA stated she wanted to be	
notified as soon as lab came in from	
x-ray. I put a note to the next nurse about	
labs being called to POA. Res. is in room	
in bed. Tylenol given at 10:00 a.m. and at	
2:00 p.m. Still awating <sic> x-ray to</sic>	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077	A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 09/16/2	ETED
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R			CHWAY DRIVE		
LAKEVIE	EW MANOR INC			INDIAN	APOLIS, IN46224		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG	come and lab res		-	IAG	Dia relation,		DATE
	Come and lab les	suits.					
	Review of the x- 08-05-11, indica fibula right ankl- trauma/pain."	ted "x-ray right tib. /					
	The nurses notes indicated the POA was notified of the x-ray results at 9:00 p.m.						
	During interview on 09-14-11 at 10:12						
	a.m., the resident's POA indicated,						
	"[resident] ankle swelled up great big.						
		igger than the calf of					
	[resident] leg. [F	Resident] said the lady					
	was trying to get	[resident] out of bed and					
		ed on it. I talked to the					
	nurse and she sa	id they would investigate					
	it. No one has to	old me anything about the					
	investigation."						
		v on 09-14-11 at 11:20					
	1 1	or of Nurses indicated "I					
	1	dent] ankle. I went down					
		m and [resident] said it					
	1	on night shift or when the					
	I -	n. [Resident] said the					
		dent]. I interviewed three					
		at no one knew anything."					
	1 -	interviews included not					
	, , ,	out day shift as well the					
		es indicated, "no." When					
		her residents were					
	interviewed, the	Director of Nurses stated,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155077	B. WING		09/16/2011
				T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L	45 BE	ACHWAY DRIVE	
	W MANOR INC			NAPOLIS, IN46224	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC 1)	DATE
	"no."				
	The federal defice Complaints IN00 IN00096396.	_			
F0226 SS=D	written policies an mistreatment, neg and misappropriat Based on intervioration facility failed to prohibition policithat when a resid family member everbal and allege administrative strallegations were In addition, when concerns of verb Practical Nurse Manager the employee fair of alleged abuse policy.	levelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. ew and record review, the ensure their abuse y was implemented, in lent, and a resident's expressed concerns of ed physical abuse, the aff failed to ensure the thoroughly investigated. In a resident expressed all abuse to the Licensed Night Shift Supervisor, led to report the incident as outlined in the facility	F0226	1. (a)The involved employed addressed as to failure to communicate a resident allegation. The nurse did not believe the resident to be reporting as an "allegation of abuse"; however, the nurse been advised to report all statements/allegations to alle administrative staff to investi and take corrective actions accordingly. (b) Resident I's allegation was reported to IS as a reportable/unusual occurrence and investigated thoroughly, according to faci policy upon administrative notification of the same. (c) regard to the concern of Res A, the DON has been addres as to thorough investigation of	f has Dw gate DH lity In sident ssed

li ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155077	B. WIN			09/16/2	011
		l .	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	CHWAY DRIVE		
LAKEVIE	EW MANOR INC			1	APOLIS, IN46224		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	MONUMENC NAMES CONDUCTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
	sampled residen	ts. [Residents "I" and			allegation, including but not		
	"A"].				limited to, interview of variou	S	
	A J.				shifts and other potentially		
					affected residents. Resident		
	Findings include	:			responsible party was contac	cted	
					by the Director of Nursing		
	1. The record for	or Resident "I" was			regarding follow-up to the		
	reviewed on 09-	13-11 at 9:55 a.m.			investigation of the incident referenced in the citation.2.	الد ع۵	
	Diagnoses include	ded but were not limited			residents have the potential		
	_	sease, hypothyroidism,			affected, Social Services		
		lisorder. These diagnoses			conducted interviews of all		
	_	t at the time of the record			interviewable residents to en	sure	
		t at the time of the record			any concerns related to staff		
	review.				treatment of residents were		
					identified, communicated to		
	During an interv	iew on 09-13-11 at 9:30			administrative staff and		
	a.m., the residen	t indicated "over the			investigated as per facility policy.3. As a means to ens	uro	
	weekend I repor	ted to the night nurse			ongoing compliance with ens		
	1	# 28] the aide [Certified			residents are free from verba		
	1	ployee # 29] wouldn't			potential physical abuse and	to	
	1	o go to the bathroom. She			ensure the facility policy is		
		_			implementing, staff have bee	en	
		have to do it myself			re-educated on abuse, (see		
		ldn't lift me, she had a			attachment D) and the facilit	-	
	bad back.' Whe	n I told her I couldn't and			Abuse policy (see attachme	•	
	that I wasn't sup	posed to she told me she			The Director of Social Service her designee will interview 5		
	had a 95 year old	d grandmother who could			random interviewable reside		
	take care of hers	elf. This is the worse I			weekly for 4 weeks, then 10		
		to. I have Parkinson's			residents per month for 3 mo	onths,	
		and I don't try to get up			then quarterly thereafter to		
					ensure any further issues are		
		an't. I told the nurse but			identified (see attachment F		
	no one else has come to talk to me about				corrective action initiated sho		
	it."				non-compliance with ensurin residents are free from verba		
					and/or potential physical abu		
	During interview on 09-13-11 at 10:40				be noted.4. As a means of	130	
	a.m., the Admini	istrator and Assistant			quality assurance, the finding	gs of	
	· ·	dicated they were			the above audits and any	-	
		J 			·		

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	155077	- 1	LDING	00	09/16/2	
		100077	B. WIN			03/10/2	011
NAME OF I	PROVIDER OR SUPPLIEF	8		1	ADDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE		
LAKEVIE	W MANOR INC			1	APOLIS, IN46224		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG				TAG			DATE
TAG	unaware of the record for reviewed on 09-10 Diagnoses include to congestive her mellitus, hypertecoronary artery of insufficiency. To current at the time Review of the number of the nu	esident's allegation. or resident "A" was 109-11 at 9:45 a.m. 11 ded but were not limited art failure, diabetes ension, atrial fibrillation, disease and acute renal these diagnoses remained the of the record review. or resident "A" was 109-11 at 9:45 a.m. 11 ded but were not limited art failure, diabetes ension, atrial fibrillation, disease and acute renal these diagnoses remained the of the record review. or resident "A" was 109-11 at 9:45 a.m. 11 diabetes ension, atrial fibrillation, disease and acute renal these diagnoses remained the of the record review. or resident "A" was 109-11 at 9:45 a.m. 11 diabetes ension, atrial fibrillation, disease and acute renal these diagnoses remained the ension ensio		TAG	corrective actions taken will reviewed during the facility's quarterly Quality Assurance meetings and the plan of act will be reviewed/revised, if warranted. The above correct measures will be completed before October 7, 20116. Place attached addendum.	ion tive on or	DATE
	labs being called	to POA. Res. is in room					
	in bed. Tylenol	given at 10:00 a.m. and at					
		wating <sic> x-ray to</sic>					
	come and lab res	-					
		ray result, dated 08-05-11 right tib. / fibula right s trauma/pain."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155077			LDING	NSTRUCTION 00	(X3) DATE COMPI 09/16/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE APOLIS, IN46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	notified of the x- During interview a.m., the resident "[resident's name big. The ankle w [resident] leg. [R was trying to get that women pulle nurse and she sai	indicated the POA was ray results at 9:00 p.m. on 09-14-11 at 10:12 e's POA indicated, e'] ankle swelled up great was bigger than the calf of esident] said the lady [resident] out of bed and ed on it. I talked to the d they would investigate old me anything about the					
	During interview a.m. the Director heard about [resi to [resident] roor happened either day shift came in person hurt [resistaff members bu When queried if only night shift b Director of Nurse interviewed if other	on 09-14-11 at 11:20 of Nurses indicated "I dent] ankle. I want down and [resident] said it on night shift or when the a. [Resident] said the dent]. I interviewed three at no one knew anything." interviews included not out day shift as well, the es indicated, "no." When ther residents were Director of Nurses stated,					
	at 1:10 p.m., title PROHIBITION,	cility policy on 09-08-11 cd "ABUSE REPORTING AND ON POLICY AND					

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	COMPI	
ANDILAN	or connection	155077	1 ' '	LDING	00	09/16/2	
		100077	B. WIN		DDDDGG GYMY GWARD GYD GODD	03/10/2	.011
NAME OF F	PROVIDER OR SUPPLIER	2		1	DDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE		
LAKEVIE	W MANOR INC			1	APOLIS, IN46224		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		and dated 01-06					
	indicated the foll	lowing:					
	"It is the policy of	of this facility that reports					
	of abuse will be	communicated to, and					
	thoroughly inves	stigated by, the correct					
	authority."						
	"1. This facility	will not permit residents					
	to be subjected to abuse by anyone,						
	including employees, other residents,						
	consultants, volunteers, staff or personnel						
	of other agencies serving the resident,						
	family members.	, legal guardians,					
	sponsors, friends	s or other individuals.					
	"9 All reports o	of a use must be reported					
		ator immediately and to					
		presentative (sponsor,					
	-	y) within 24 hours of the					
		overy of the incident."					
	· F · · · · · · · · · · · · · · · · · ·	,					
	This federal defi	ciency relates to					
	Complaints IN00	0094814 and					
	IN00096396.						
	3.1-28(c)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155077	B. WIN			09/16/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			45 BEA	CHWAY DRIVE		
	W MANOR INC			INDIAN.	APOLIS, IN46224		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		E	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
F0241							
SS=E		nces each resident's dignity					
	and respect in full recognition of his or her						
	individuality.	· ·	. coogorc				
	Based on observation, record review and interview, the facility failed to ensure and		F0	241	Involved Staff were		10/07/2011
					immediately re-educated upon facility notification of observed		
protect the resident's dignity for 3 of 10				concerns.Residents B, G, I L			
	sampled and 2 of	f 2 supplemental sampled			K have been assessed/addre		
	residents. [Resid	lent "B", "G", "I", "L"			by social services to ensure	each	
	and "K"].				resident did not incur latent		
	_				negative effects of the staff	· to	
Findings include	"		interactions descr	ensure care needs are being			
					addressed by nursing staff. 2		
	1 During an obs	eservation on 09-08-11 at			all residents have the potenti		
		ent "K" was seated in a			be affected, Social Services		
	-	ent to the doorway to the			conducted interviews of all		
		e resident stated to			interviewable residents to en any concerns related to staff		
					interaction with residents we		
		Aide- Employee #17,			identified and corrective action		
	_	e in there [in reference to			initiated, as warranted.3. As	а	
		?" With other residents			means to ensure ongoing		
		ing by, the CNA stated to			compliance with ensuring and	d	
		n't you know how to say,			protecting resident dignity, nursing staff were re-educate	ed on	
	please?"				Resident Rights (see attachi		
					G) and appropriate resident	·	
	2. During an obs	servation on 09-13-11 at			interaction. The DON or her		
	12:25 p.m., Resid	dent "G" was being			designee will make rounds tv		
	toileted by CNA-	-Employee #7. As the			daily on scheduled work days 4 weeks, then twice weekly for		
	resident remained	d on the commode, the			weeks, then weekly thereafte		
		the resident's buttocks as			ensure observations are made		
	[resident's] 'boot	y.' The resident looked			staff to resident interactions,		
		ut didn't say anything.			ensuring that residents are	,	
	ap at the crar, out drain toug unguing.				treated in a dignified manner (see attachment H). Should concerns be noted, immediate corrective		
	3 During observ	rvation on 09-09-11 at					
	_	ent "B" indicated a need			action shall be taken. The	•	
	, u.iii., ixesiux	III D IIIdioated a licea					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI					
AND PLAN	OF CORRECTION	155077	A. BUI	LDING		09/16/20	
		100011	B. WIN		PRESIDENCE CONTROL CON	03/10/20	J11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE		
LAKEVIE	EW MANOR INC			1	APOLIS, IN46224		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	VAI OLIO, IN40224		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	for incontinence	care. The nursing staff			Director of Social Services o	r her	
	was notified and as the CNA pulled the			designee will interview 5 random			
		esident, towards the end			residents weekly for 4 weeks then 10 residents per month		
	of the bed, a urin				months, then quarterly there		
	· ·	en the resident's legs,			to ensure any further issues		
	1 ^	side the urinal. When			identified (see attachment F) and	
	_	resident indicated the			corrective action taken, if	,	
		because the night shift			warranted. 4. As a means of quality assurance, the finding		
		lent] to have an accident			the above audits and any		
	_	nt on the bedding.		corrective actions taken will be reviewed during the facility's			
		S					
	4. During intervi	nterview on 09-09-11 at 8:30			quarterly Quality Assurance meetings and the plan of act	ion	
		d family member was			revised, if warranted.5. The		
	· ·	n dining room, with			above corrective measures v		
		he family member			completed on or before Octo		
		sing staff frequently did			7, 2011.6. Please see attac addendum.	nea	
		esident with [resident]			addonadiii.		
	_	e in the morning just to					
		ntures are in, wheelchair					
		the table and the sugar					
	1	ning has been opened."					
		- *					
	5. During an inte	erview on 09-09-11 at					
	8:20 a.m., Reside	ent "L" indicated					
	[resident] was at	the facility for therapy.					
	In addition, the re						
	[resident] had pro	eviously worked there					
	and some of the	staff members mentioned					
	they were going	to check the resident's					
	personnel file to	see if there was any					
	disciplinary action	ons, "fired" or "written					
		een fired or written up					
	for anything. So	me of the staff are nice					
	but some are just	plain hateful.					

PRINTED: 10/11/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	COMPI	
		155077	A. BUI B. WIN	LDING IG		09/16/2	011
NAME OF I	PROVIDER OR SUPPLIER		P	_	DDRESS, CITY, STATE, ZIP CODE		
				1	CHWAY DRIVE		
	W MANOR INC			<u> </u>	APOLIS, IN46224		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		DATE
	Sometimes I nee	d help getting to the					
	bathroom, they are slow in coming and I						
		During this interview, a					
	strong smell of u	rine permeated the air.					
	6 During an inte	erview on 09-13-11 at					
	_	ent "I" indicated "Once in					
	ŕ	accident [incontinent of					
	urine]. I don't lil	ke that happening, so I try					
	to figure out who has me that day, what						
	time their break is and what time they will						
	be going home. That way I try to work						
	my bathroom nee	eds around their					
	schedule."						
	7. Review of a s	ection of the Resident					
	Handbook, titled	"Your Rights as a					
	_	esident," on 09-08-11 at					
	-	as 'revised 10-2010,					
	indicated the foll	owing:					
	 "You keen all vo	ur fundamental civil or					
		l liberties when you are					
		rsing home. Basic Right:					
	You have the rig	ht to be treated with					
	-	ity in recognition of you					
	_	preferences. You have					
		ty care and treatment that					
	is fair and free fr	om discrimination."					
	Living Accomm	nodations and Care - You					
	_	Receive care in a manner					
		and enhances your					
	quality of life."						

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE S COMPL	
		155077	A. BUIL B. WING			09/16/2	011
	ROVIDER OR SUPPLIER W MANOR INC		STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DRIVE INDIANAPOLIS, IN46224				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0282 SS=D	facility must be proin accordance with plan of care. Based on observatinterview, the factoresident's plan of that when resident requiring total as incontinence, repthe facility failed appropriate service plan of care for 3 for activities of definition 10. [Residents "Intercord for reviewed on 09-00 Diagnoses included to paraplegia, hypneurogenic bladd remained current review.	to provide the ces as outlined in the of 4 residents reviewed aily living in a sample of B", "F", and "J"]. The Resident "B" was 19-11 at 11:50 a.m. led but were not limited	F0:	282	1. The needs of Residents I and J were addressed as foll a. Resident B's assignment sheet was reviewed/updated caregivers re-educated as to routine incontinence needs/c.b. Resident F's physician w notified of missed lab draws orders obtained and followed Resident J's care plan was reviewed and revised, as indicated, to address incontinence care as well as care and staff were immediat re-educated.2. As all resider have the potential to be affect the following corrective meas were taken:3. As a means to ensure ongoing compliance where the following of the plan of care for residents requiring total assistance with incontinence repositioning, and oral care, Nursing staff were re-educate nurse aide assignment sheet specifically as it relates to oral/dental care, incontinence care, and pressure ulcer prevention (see attachments).	and are as and l.c. oral tely onts steed, sures o with are great are	10/07/2011
	assessment male	and the resident was			and J). The DON or her desi	gnee	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		A. BUIL	DING	NSTRUCTION 00	(X3) DATE S COMPL 09/16/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER		B. WINC		DDRESS, CITY, STATE, ZIP CODE	09/16/2	011
	EW MANOR INC				CHWAY DRIVE APOLIS, IN46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	alert and oriented incontinent of be extensive assista. The resident's pla 07-15-11, indicated up to extensive/2 ADL's [activities paralysis, pain, which was notified, who unidentified CNA that compared incontinent episons of the changed." The resident state be changed. The resident state be changed. The resident state be changed. The check and change "around 4:00 a.m. was notified, who unidentified CNA the CNA entered supplies and the to be changed." "what [pause] like stated "No, I'm dechanged." The CNA incompared to the changed."	d with no memory loss, owel and required nee with hygiene. an of care, dated ted the resident "requires assist in performing of daily living] due to weakness, incontinency, and spinal cord injury. With transfers, toileting, set <sic> for meals." The plan of care included the each shift and after each ode." Wation on 09-09-11 at sident was observed lying and odor permeated the air. The licensed resident indicated the elecame to the room to the for incontinence was and to clean the resident. A to clean the resident. If the CNA responded the linens?" The resident intity, I need to be continence with the continence was and the resident intity. I need to be continence with the room, without the continence with the continence with the continence with the continence with the continence without the continence with the continence without the continence with the contine</sic>			will make rounds twice daily scheduled work days for 4 w then twice weekly for 4 week then weekly thereafter to ensobservations are made of residents in need of said car confirm said care is provided timely manner and per the placare (see attachment K) and corrective action taken, as warranted.4. As a means of quality assurance, the finding the above audits and any corrective actions taken will reviewed during the facility's quarterly Quality Assurance meetings and the plan of act revised, if warranted. The abocorrective measures will be completed on or before Octo 7, 2011	eeks, (s, sure e and l in a lan of d gs of be ion ove	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155077		(X2) MUL A. BUILD B. WING		00	(X3) DATE S COMPL 09/16/2	ETED	
	PROVIDER OR SUPPLIER			45 BEA	DDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE APOLIS, IN46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	1	eed to change me." The OK I'll be right back."					
	the resident's roo #14 #15 and #16 bedcovers down bed. The resider between legs. We resident indicated by the night shift bed wet if I uring the resident to the resident was turn observed on the substitution of the buttocks and the 2. The record for reviewed on 09-0 again on 09-13-1 Diagnoses for Re- were not limited accident, diabete hypertension. The current at the time The resident had hospital and retu	r Resident "F" was 08-11 at 2:35 p.m. and 1 at 10:00 a.m. esident "F" included but to cerebral vascular s mellitus, syncope, and nese diagnoses remained ne of the record review. been seen at a local rned to the facility with a					
	letter from the ra dated 07-01-11, nursing staff as f "We will need A	diology department, which instructed the					
		have enclosed an order					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE COMPL		
		155077	A. BUII B. WIN		·	09/16/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIER			45 BEA	CHWAY DRIVE		
	W MANOR INC				APOLIS, IN46224		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1710		Please call the Pre-Op		1110			DITTE
		ame of hospital] to make					
	· ·	Please try to get in for					
	this at least 1 we	, ,					
	procedure."	1 ,					
	•						
	The laboratory b	lood work indicated					
	1	Metabolic Panel, a					
	Complete Blood	Count with Differential,					
	and Activated PT	T, Anesthesia clearance					
	and a Prothromb	in Time with INR					
	[international no	rmalization ratio].					
		iew on 09-09-11 at 11:20					
	a.m., the Unit Ma	•					
		Employee #2, indicated					
	l ⁻	ent] had orders to go out					
		erebral angioplasty. The					
		work - blood tests] were					
		nday [08-20-11]. The					
		wn and I didn't notify the					
	1 ^ *	nurse indicated she did					
	not read the instr						
		d for the testing to be					
	_	st 1 week prior to the					
	procedure.						
	The resident had	been readmitted to the					
		ief hospitalization for a					
	1 *	ion while visiting a					
	family member.						
	· ·	harge summary, dated					
		ted the resident had a					
	· ·	ant for recent embolic					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPI 09/16/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE APOLIS, IN46224	03/10/2	
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	SHOULD BE COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
TAG	CVA [cerebral varesidual left sided femoral neck fract Worrisome is the been dropping the leaning to the rigreturn to the hosp exceeds 101.5 F dizziness, altered syncopal episode Consults - Thyroschedule an apport for follow-up of carotid dopplers. The resident's recorder, dated 08-0 the nursing staff stimulating horm hypothyroidism.' During interview a.m., the Assistant Employee #9 inductions the nursing had not be spoke with the nursing had	ascular accident] with d weakness after left eture and repair. a fact that [resident] has ings from right hand and the more. Patient should bital if temperature [Fahrenheit] or if I mental status, or as occur. New order: id Consult, Nurse/staff to bintment within 1 month thyroid nodule found on the cord included a physician of		TAG	CROSS-REPERRED TO THE APPROPRIED TO THE APPROPRI	NATE	DATE
		ssistant Director of "since there was no					
	_	er must have been a					
		interviewed if the ary had been reviewed for					
		e nodule as indicated on					
	the carotid doppl	ers and a thyroid consult Assistant Director of					
	1						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077		A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹		l	CHWAY DRIVE		
LAKEVI	EW MANOR INC			INDIAN	APOLIS, IN46224		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	1	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	Nurses stated, "I	,		IAG	DEFICIENCE,		DATE
	Nuises stated, 1	didn't see that.					
	12:40 p.m., titled	ty policy on 09-13-11 at d'Re-Admission type and underscored], ed the following:					
	documentation of condition of each the facility after hospital stay or uday hospital stay to hold bed)."	provide accurate of the mental and physical in resident re-admitted to a minimum of a 23 hour up to a maximum of 15 or (or resident did not pay PHYSICIAN ORDERS					
	be obtained as for Transcribe the	n, physician orders must ollows: he re-admission order I sent from the hospital or					
	physicians office	•					
	* *	lete ancillary orders."					
	Check transfer sl	APPOINTMENTS - 1. heet for outside scheduled d place on calendar."					
	reviewed on 09-1 Diagnoses for re were not limited condition, bipola with agitation.	or Resident "J" was 09-11 at 2:15 p.m. sident "J" included but to schizophrenic ar disorder and dementia These diagnoses remained the of the record review.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE (ETED	
		155077	B. WIN	G		09/16/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE		
LAKEVIE	W MANOR INC			INDIAN	APOLIS, IN46224		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	IAG	DEFECE ()		DATE
	09-08-11 at 10:30 assessed by the U Practical Nurse-F	I tour of the facility on 0 a.m., Resident "J" was Unit Manager Licensed Employee #4 as "total					
	care."						
	dated 08-18-11, i required assistant living due to total	sident's plan of care, ndicated the resident ce with activities of daily I dependence for bed rs, eating and toilet use.					
	Incontinence, dat the resident was and required the "approach reside	nt at least every two d or check for evidence					
	Care" and dated or resident "requires care due to edent on staff for oral cognition." Inter	an of care, titled "Dental 08-18-11, indicated the s special attention to oral rulous <sic>, dependent care and impaired eventions to this plan of rovide and assist with oral needed."</sic>					
	the resident was due to "depender	ated 08-18-11, indicated at risk for pressure ulcers ace on staff for bed ars and repositioning."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE : COMPL		
		155077	A. BUII B. WIN		<u></u>	09/16/2	011
NAME OF F	PROVIDER OR SUPPLIER		B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
		•		I	CHWAY DRIVE		
LAKEVIE	W MANOR INC			INDIAN	APOLIS, IN46224		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
1710		this plan of care included		1710	<u> </u>		DATE
		assist resident with					
	_	sitioning at least every					
		ide incontinent care after					
	each incontinent	episode."					
ı							
	During an observ	vation on 09-09-11 at					
	8:15 a.m., the res	sident was seated in a					
		om. The resident cried					
	•	on entering the resident's					
	•	nt's tongue/mouth was					
		with a thick white					
		Assistant Director of					
	Nurses was notif						
		A to provide oral care to					
	the resident. The	and returned with					
	•	e CNA provided oral					
		ent, thick white clumps					
		om the resident's tongue					
	and oral cavity.	om me resident's tongue					
ı							
	Further observati	ion at 10:10 a.m., the					
	resident remained	d seated in the					
	wheelchair.						
	•	ade to check the resident					
		CNA- Employee #16					
		ident was "up and in the					
		about 7:30 a.m." The					
	CNA pulled dow						
	resident's slacks and indicated the resident						
		quest was made to transfer					
	the resident into	bed to check skin.					

PRINTED: 10/11/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/16/2011
	PROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP CODE ACHWAY DRIVE JAPOLIS, IN46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	1	es #14 and #16 exited the and approximately 10 arned with the			
	the wheelchair, f hooks onto the sl positioned benea transferred the re CNA's removed unfastened the in strong smell of u The resident was brief inside of the was saturated and	•			
	This federal defice Complaints IN00 IN00096396. 3.1-35(g)(2)	•			
F0309 SS=G	must provide the r to attain or mainta physical, mental, a	st receive and the facility necessary care and services in the highest practicable and psychosocial well-being, in the comprehensive plan of care.			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPI	
		155077	B. WIN			09/16/2	011
			_!	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	NAME OF PROVIDER OR SUPPLIER			45 BEA	CHWAY DRIVE		
LAKEVIE	EW MANOR INC			1	APOLIS, IN46224		
(X4) ID	CUMMADV	STATEMENT OF DEFICIENCIES	_	ID	· -		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710			F0	309	Resident A was treated a	t the	10/07/2011
		review and interview, the	FU	1309	hospital for her decline in	it tile	10/07/2011
		ensure the nurses			condition.2. As all residents	have	
	_	cumented accurate and			the potential to be affected,		
	ongoing assessm	ent, in that when a			Nurse's Notes for the last 30	days	
	resident was idea	ntified with a history of			were reviewed to ensure a		
	congestive heart	failure, pneumonia and			complete and thorough	_	
	1 ~	edema and required			assessment was conducted	tor	
	1	ics to treat the resident's			any resident exhibiting a		
					change/decline in condition warranting need of ongoing		
		oms, the nursing staff			assessment. Any concerns r	noted	
	_	ze the resident's ongoing			were reviewed with the appli		
		ess and decline in			nurse and re-education		
	condition over a	period of 11 days which			provided.3. As a means to		
	resulted in the re	sident being transferred			ensure ongoing compliance		
	to the hospital w	ith volume overload and			the provision of documented	,	
	pulmonary edem	a. This deficient practice			accurate and ongoing		
	1 ^	esidents reviewed for			assessment for residents exhibiting a decline and/or		
		tle of 10. [Resident "A"].			change in condition, License	d	
		ne of to. [Resident 11].			nursing staff were re-educate		
	F: 1: . 1 1				Nursing Charting policy,		
	Findings include): 			specifically pertinent charting	g and	
					assessment to be completed		
	The record for re	esident "A" was reviewed			changes in condition or unst		
	on 09-09-11 at 9	:45 a.m. Diagnoses			conditions (see attachment		
	included but wer	re not limited to			The DON or her designee wi review 24-Hour Condition Re		
	congestive heart	failure, diabetes mellitus,			and Nurse's Notes daily, on	эронз	
	1	rial fibrillation, coronary			scheduled work days, to ens	ure	
	artery disease an				appropriate and thorough		
		hese diagnoses remained			assessment is made, interve	ention	
	1	•			sought if warranted, and the		
	current at the tim	ne of the record review.			same documented (see		
					attachment C). Should cond		
		physician orders			be noted, immediate correcti action shall be taken.4. As a		
	originally dated	04-11-11 for Lasix [a			means of quality assurance,		
	diuretic] 40 mg.	[milligrams] 3 tablets			findings of the above audits		
	(120 mg) by mor	uth every morning and 2			any corrective actions taken		
	tablets (80 mg) e	, ,			be reviewed during the facilit		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 09/16/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE APOLIS, IN46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	Review of the redated 06-29-11, in requires use of an asal cannula dustailure, chronic adisease and pneus [oxygen saturation %." Intervention included Duonebe every 6 hours, us nasal cannula." The plan of care dated 06-30-11, in at risk for respiral Interventions included HOB [he facilitate respiration oxygen as ordered medications as on urse if signs or further evaluation and responsible procession of the neuron of t	sident's plan of care, indicated the resident oxygen at 2 liters per et to congestive heart obstructive pulmonary monia to keep sats on] level greater that 90 ms to this plan of care [a respiratory treatment] se oxygen at 2 liters per related to COPD, and indicated the resident was atory distress. luded "observe for signs f respiratory distress, ad of bed] as needed to cory effort, administer ed, administer redered, advise the charge symptoms are noted for an and possible physician party notification." The service of the physician country indicated the ed, and physician country notification." The service of the physician country indicated the ed, and physician country notification. The service of the physician country notification of the physician country notification of the physician country notification of the physician country notification. The property of the physician country notification of the physician country notification of the physician country notification of the physician country notification. The physician country notification of the physician country notification of the physician country notification of the physician country notification. The physician country notification of the physician country notification o		TAG	quarterly Quality Assurance meetings and the plan of ac revised, if warranted.5. The above corrective measures completed on or before Oct 7, 2011.	tion e will be	DATE
	increased Lasix [[a diuretic] to 10 mg					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		p. 4110	STREET A	DDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE APOLIS, IN46224	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	[milligrams] BID 3 days. POA [po about medication Will continue to symptoms] of infreactions. Will for the next nurses in 08-28-11 at 5:00 which indicated to "Pt. [patient] stat stomach hurting, given for pain, which in the patient of the patient	[two times a day] times over of attorney] notified a changes, resident aware. monitor for s/s [signs and fection and adverse follow plan of care." In the entry was dated a.m., 11 days later, the following: es having spell. c/o tylenol [an analgesic] ras effective." 19-11 1:00 a.m., "Pt. c/o ain and not being able to dent was given tylenol chair. Resident also given Both meds ere effective." 19-11 at 6:30 a.m., dent's oxygen saturation of the content of the content and turned to level the minutes later and the content of th					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		(X2) M A. BUII		NSTRUCTION 00	COMPI	LETED		
		155077	B. WIN	G		09/16/2	011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DRIVE INDIANAPOLIS, IN46224					
	W MANOR INC			<u> </u>	4FOLIS, IN40224			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Nurses note date	d 08-30-11 at 8:00 a.m.						
	Awake, up in wh	eelchair. O2 [oxygen]						
		on RA [room air]. Lungs						
		ninished]. O2 [oxygen]						
	places <sic. 2i<="" at="" td=""><td></td><td></td><td></td><td></td><td></td><td></td></sic.>							
	confusion. 1+ pe	dal edema. O2 sat						
	recheck <sic> at</sic>	1 hr. [hour] 89% - O2 at						
	2L. MD [Medical	al Doctor] notified.						
	Family notified.	N.O. [new order]						
	received to send	out to [name of local area						
	hospital]."							
	A respiratory the	rapist notation on						
	08-30-11 at 11:3	0 a.m., also indicated the						
		sounds remained						
		Pt. [patient] continues to						
	_	o keep oxygen level up]						
	Resident is going	g to the hospital."						
	During an interv	iew on 09-14-11 at 12:30						
		Therapist- Employee						
	#21 indicated the							
		a treatment and I put the						
	probe on [resider	-						
	_	nt. [oxygen saturation						
	level] was 69 %	- 70 %. I put the oxygen						
	on [resident] at 2	liters. I rechecked the						
	O2 Sat. and it can	me up to 88 % - 90 %. It						
	kept dropping a l	little bit. I went out to tell						
	the nurses, they	were in report. She [in						
	reference to the r	nurse] went to call the						
	MD [Medical Do	octor]. I worked with						
	~	t] 30 - 40 minutes. I						
	finally got it [in 1	reference to the oxygen						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M0Q811

Facility ID:

000032

If continuation sheet

Page 36 of 64

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		(X2) MU A. BUII B. WIN	LDING	nstruction 00	(X3) DATE S COMPL 09/16/2	ETED	
	PROVIDER OR SUPPLIEI	!!	<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE APOLIS, IN46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	left and went on the next treatmer. Toward the end [resident's family the nurse said the ate lunch she was out [in reference [name of nurse] wasn't acting rig. During an interval.m., a concerned indicated, "[Resident's coughing. It was happened before just like the same They told me the additional Lasix help." The Medication indicated the result additional dosage the physician from through 08-20-1. Review of the help hysical, dated of following: " presents to help mursing home with the physical of t	y member] came in and at after [name of resident] is going to send [resident] to the hospital]. I told that [name of resident] tht." iew on 09-14-11 at 10:12 d family member dent] kept coughing and is a real deep cough. This in April and it seemed is thing all over again. By would give [resident], but it didn't seem to Administration Record ident received the e of Lasix as ordered by om 08-17-11 at 7:00 p.m. 1 at 7:00 p.m. Ospital History and 08-30-11, indicated the					

NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET	ON
NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET	ON
LAKEVIEW MANOR INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (FACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET)	ON
PREFIX (FACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET	ON
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET	ON
CROSS-REFERENCED TO THE APPROPRIATE	
THE REGULATOR OF ESCHELITH THIS BUT ORGANION) THE	
short of breath coughing was	
hypoxic and has been placed on BiPAP	
[breathing treatments] per the emergency	
room physicians. the chest x-ray show	
bibasilar infiltrates and pulmonary edema	
is grossly volume overloadedhas an	
elevated white count. There is concern	
for coexistent pneumonia and had	
abdominal discomfort as well. [Resident]	
has progressive lower extremity edema	
and abdominal swelling. Lungs: very	
coarse and crackly without wheezes, very	
diminished in the bases bilaterally.	
Abdomen: markedly distended but non	
tender. Probably has ascites - and most	
likely related to edema. [Resident] has	
abdominal wall edema. Extremities:	
There is 3+ lower extremity edema to the	
thighs bilaterally. Assessment: The	
patient has acute on chronic respiratory	
failure. The etiology is not quite clear and	
is probably multifactorial, including at	
least in part some component of	
congestive heart failure, pulmonary	
edema, pleural effusions, possible	
superimposed pneumonia and COPD	
exacerbation."	
Review of the hospital cardiology consult	
report, dated 08-30-11, indicated "Today	
[resident] is short of breath coughing.	
[Resident] is grossly volume overloaded.	
On admission, [resident] blood pressure	
was tenuous with systolics running in the	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A DIFFERENCE 00 COMPLETED			
ANDIEAN	or connection	155077	A. BUILDING B. WING		09/16/2011
	PROVIDER OR SUPPLIER		STREET 45 BE	ADDRESS, CITY, STATE, ZIP CODE ACHWAY DRIVE NAPOLIS, IN46224	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0312 SS=E	discomfort as we elevated white co of 3. This would impending sepsis This federal defic Complaint IN00 3.1-37(a)	ciency relates to			
33-E	to maintain good repersonal and oral Based on observation interview, the fact activities of daily dependent residents were as assistance with interpositioning and failed to provide for 4 of 4 resident of daily living in [Residents "B", "Findings include 1. The record for reviewed on 09-0	nutrition, grooming, and hygiene. Action, record review and cility failed to ensure valving were provided for ents, in that when sessed as requiring total accontinence, and oral care, the facility the appropriate services at the reviewed for activities a sample of 10. [F", "G", and "J"].	F0312	1. The needs of Residents E and J were addressed as foll a. b. and c. Residents B, F a G's assignment sheets were reviewed/updated and careg re-educated as to routine incontinence needs/care .a. Resident J's care plan was reviewed and revised, as indicated, to address incontinence care as well as care and staff were immediar re-educated.2. As all resident have the potential to be affect the following corrective measure ongoing compliance the following of the plan of cafor residents requiring total assistance with incontinence repositioning, and oral care,	oral tely nts cted, sures owith are

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155077 09/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DRIVE LAKEVIEW MANOR INC INDIANAPOLIS, IN46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Nursing staff were re-educated on to paraplegia, hypertension, and nurse aide assignment sheet useneurogenic bladder. These diagnoses specifically as it relates to remained current at the time of the record oral/dental care, incontinence review care, and pressure ulcer prevention (see attachments I and J). The DON or her designee Review of the initial Minimum Data Set will make rounds twice daily on assessment indicated the resident was scheduled work days for 4 weeks, alert and oriented with no memory loss, then twice weekly for 4 weeks. incontinent of bowel and required then weekly thereafter to ensure observations are made of extensive assistance with hygiene. residents in need of said care and confirm said care is provided in a The resident's plan of care, dated timely manner and per the plan of 07-15-11, indicated the resident "requires care (see attachment K) and corrective action taken, as up to extensive/2 assist in performing warranted. 4. As a means of ADL's [activities of daily living] due to quality assurance, the findings of paralysis, pain, weakness, incontinency, the above audits and any C5 - C7 [cervical] spinal cord injury. corrective actions taken will be reviewed during the facility's Extensive assist with transfers, toileting, quarterly Quality Assurance bed mobility and set <sic> for meals." meetings and the plan of action Interventions to the plan of care included revised, if warranted.5. The "provide pericare each shift and after each above corrective measures will be incontinent episode." completed on or before October 7, 2011. During an observation on 09-09-11 at 7:55 a.m., the resident was observed lying in bed. A pungent odor permeated the air. The resident stated "I'm soiled - I need to be changed." The resident indicated the last time someone came to the room to check and change for incontinence was "around 4:00 a.m." The licensed nurse was notified, who instructed an unidentified CNA to clean the resident. The CNA entered the room, without

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155077	A. BUI	LDING	00	09/16/2	
		133077	B. WIN			09/10/20	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
I AKE\/IE	EW MANOR INC			1	CHWAY DRIVE APOLIS, IN46224		
					711 OLIO, 11440224		215
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
-		resident indicated "I need	1	_			
	1 **	The CNA responded					
		•					
	"what [pause] like linens?" The resident stated "No, I'm dirty, I need to be						
	· ·	CNA responded "oh."					
		her instructed the CNA					
	"you know like v						
	1 -	eed to change me." The					
	CNA indicated "OK I'll be right back."						
	A few minutes later three CNA's entered						
	the resident's room., CNAs- Employees						
	#14 #15 and #16. CNA #16 pulled the						
		toward the end of the					
	bed. The residen	nt had a urinal positioned					
		hen interviewed, the					
	resident indicated	d the urinal was put there					
	by the night shift	aide so "I didn't get the					
	bed wet if I urina	nted." CNA #16 turned					
	the resident to the	e left side and as the					
	resident was turn	ned stool could be					
	observed on the i	resident's bilateral					
	buttocks and the	incontinence pad. CNA					
	#16 proceeded to	use wipes to clean the					
	stool from the res	sident's rectal area. The					
	resident's scrotur	n was red in color. CNA					
	#14 proceeded to	wet a washcloth and					
	handed the wette	ed washcloth to CNA #16.					
	The CNA wiped	the resident's buttocks					
	and rectal area, to	urning the soiled cloth					
	after each wipe.	The CNA used a towel to					
	dry the resident a	and then placed the soiled					
	towel onto the be	ed linens. The CNA then					
	applied a white c	ream [unlabeled] to the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
111,1212111	or conditions	155077	A. BUII			09/16/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	CHWAY DRIVE		
LAKEVIE	EW MANOR INC			1	APOLIS, IN46224		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		al buttocks. CNA #16					
		ent from lying on left					
	side to back and then used wipes to clean						
		ent scrotum, first down					
		the other. The urinal					
		ned between the resident's					
	thighs and his penis placed inside the						
	opening of the urinal.						
	2. The record for Resident "F" was						
	reviewed on 09-08-11 at 2:35 p.m. and						
	again on 09-13-11 at 10:00 a.m.						
	Diagnoses for Resident "F" included but						
	were not limited	to cerebral vascular					
	accident, diabete	s mellitus, syncope, and					
		nese diagnoses remained					
	**	e of the record review.					
	The resident was	re-admitted to the					
	facility on 09-12	-11, after a recent					
	· -	or a procedure and					
	_	chnoid hemorrhage and					
		on was assessed by the					
	_	equire total care for all					
	activities of daily	-					
		C					
	~	vation on 09-13-11 at					
	l '	sident was lying in bed					
	with the head of the bed elevated and the						
	gastrostomy tube	e feeding infusing at 65					
	c.c. per hour. Du	iring a further					
	observation on 09	9-13-11 at 12:00 p.m.,					
	the resident rema	ined on back with the					
	head of the bed e	elevated as observed					
	previously. A red	quest was made to check					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155077	B. WIN			09/16/2	011
		1	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEF	₹			CHWAY DRIVE		
LAKEVIE	EW MANOR INC				APOLIS, IN46224		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the resident for i	ncontinence. Licensed					
	Practical Nurse- Employee #25 turned the						
	feeding pump to	the off position, lowered					
	the head of the b	ped, pulled the bed linens					
		bed, and turned the					
		ght side. Although the					
	resident to the right side. Atthough the resident was not incontinent, the resident's						
	buttocks were slightly reddened and had						
	indentations across the upper thighs and hip area from the incontinent brief.						
	nip area from the incontinent brief.						
	3. The record for Resident "G" was						
	reviewed on 09-13-11 at 1:00 p.m.						
		ded but were not limited					
	_	nation, peripheral					
		nentia, gout, congestive					
	1 .	diabetes mellitus. These					
		ned current at the time of					
	the record review						
	the record review	<i>N</i> .					
	Review of the M	Iinimum Data set					
	assessment, date	ed 06-16-11, indicated the					
		l assistance with toileting					
	1	vas incontinent of urine.					
	A plan of care. d	lated 06-17-11, indicated					
	_						
	the resident "required up to extensive assist in performing ADL's due to						
	impaired vision, pain to lateral knees and						
	unsteady balance."						
	unsicady baiding	.					
	During an observ	vation on 09-13-11 at					
	12:30 p.m., CNA - Employee #7 toileted						
	_	e CNA had a gait belt					
	1						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155077	A. BUI	LDING	00	09/16/2	
		133077	B. WIN			09/10/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE		
I AKE\/IE	EW MANOR INC			1	APOLIS, IN46224		
			_,		Al OLIO, 11170227		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110		. The resident was	-	1110			Ditte
	observed seated on the commode with the walker adjacent to the commode. The						
	1	ying anything, left the					
	· · · · · · · · · · · · · · · · · · ·	the resident remained on					
		The CNA returned to the					
		earrying a towel and two					
		CNA turned on the					
		lwashing sink and wetted					
	the two washcloths. The CNA instructed						
	the resident to stand up and then with the first washcloth the CNA cleansed the						
		ks area, wiping around					
		ng the washcloth and					
	1	he CNA then dried the					
		ks. The CNA then took					
		cloth and wiped between					
	the resident's leg	s and then dried the area.					
	4. The record for	r Resident "J" was					
		09-11 at 2:15 p.m.					
		sident "J" included but					
	were not limited						
		r disorder and dementia					
	· •	These diagnoses remained					
	1	ne of the record review.					
	During the Initial	l tour of the facility on					
	1	0 a.m., resident "J" was					
		Jnit Manager Licensed					
	I -	Employee #4 as "total					
	care."	1 -2					
	Review of the res	sident's plan of care,					

000032

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		(X2) MULTIPLE C	ONSTRUCTION 00	COM	TE SURVEY SPLETED 6/2011	
	PROVIDER OR SUPPLIER		45 BE	ADDRESS, CITY, STATE, ZIP ACHWAY DRIVE NAPOLIS, IN46224	_	#2011
(X4) ID	-	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE
	required assistan	indicated the resident ce with activities of daily ependence for bed rs, eating and toilet use.				
	Incontinence, da the resident was and required the "approach reside	nt at least every two d or check for evidence				
	Care" and dated resident "require care due to edent on staff for oral cognition." Inter	an of care, titled "Dental 08-18-11, indicated the s special attention to oral rulous <sic>, dependent care and impaired eventions to this plan of rovide and assist with oral needed."</sic>				
	8:15 a.m., the results wheelchair in room and moaned. Up room, the resider observed coated substance. The A Nurses was notifinstructed a CNA the resident. The resident's room,	to provide oral care to				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	155077	A. BUIL	DING	00	COMPL 09/16/2	
		155077	B. WIN			09/10/2	011
NAME OF I	PROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
I AKE\/IE	EW MANOR INC			l	CHWAY DRIVE IAPOLIS, IN46224		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		ent, thick white clumps		mo	•		DATE
		om the resident's tongue					
		on the resident's tongue					
	and oral cavity.						
	Eurther charget						
	Further observation at 10:10 a.m., the resident remained seated in the wheelchair.						
	wheelchair.						
	A magningst raing mode to check the magidant						
	A request was made to check the resident for incontinence. CNA- Employee #16 indicated the resident was "up and in the wheelchair since about 7:30 a.m." The						
	CNA pulled dow						
		and indicated the resident					
		juest was made to transfer					
		bed to check skin.					
		es #14 and #16 exited the					
		nd approximately 10					
	minutes later retu	irned with the					
ı	mechanical lift.						
	_	ioned the lift in front of					
		astened the appropriate					
		ing that was already					
	1 *	th the resident, and then					
		esident to bed. The					
	CNA's removed	the resident's slacks,					
	unfastened the in	continent brief, and a					
	_	rine permeated the air.					
	The resident was	wearing one incontinent					
	brief inside of the	e other and the inner brief					
	was saturated and	d heavy with urine. The					
	CNA's indicated	they were unaware the					
	resident had beer	n placed in two					

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NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR INC (X4) ID SUMMARY STATEMENT OF DETICIENCES PREFX (EACH DEPTICIENCY MUST BE PERCEDED BY FILL TAGE INDIANAPOLIS, INA6224 Incontinent briefs. CNA #14 exited the resident's room, entered the bathroom and returned to the bedside with two wet washcloths and a towel. CNA #16 took the washcloth from CNA #14 and washed the resident's lower abdomen in a back and forth motion and then dried the area with a towel. The CNA took the second washcloth and repeated washing the resident's lower abdomen with the wetted washcloth and then dried the area. CNA #14 assisted in turning the resident to the right side and CNA #16 used the same washcloth, wiped the resident's buttocks and then dried the area. 5. Review of policy on 09-13-11 at 12:40 p.m., titled "PERINEAL CARE [bold type and underscored], dated 01-06, indicated the following: "Purpose [underscored]: to cleanse the perineum for prevention of infection, irritation and to contribute to the resident's positive self-image." "Equipment [underscored] May include washcloth(s), disposable wipes, towel(s),	NAME OF PROVIDER LAKEVIEW MAN (X4) ID PREFIX TAG Incontreside return washed the wa the res and fo with a washed reside washed and th 5. Re p.m., to and un the foo "Purpoperine irritati positiv "Equip washed peri-w	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR INC (X9) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGILATORY OR ISC IDENTIFYING INFORMATION incontinent briefs. CNA #14 exited the resident's room, entered the bathroom and returned to the bedside with two wet washcloths and a towel. CNA #14 and washed the resident's lower abdomen in a back and forth motion and then dried the area with a towel. The CNA took the second washcloth and repeated washing the resident's lower abdomen with the wetted washcloth, wiped the resident's buttocks and then dried the area. 5. Review of policy on 09-13-11 at 12:40 p.m., titled "PERINEAL CARE [bold type and underscored], dated 01-06, indicated the following: "Purpose [underscored]: to cleanse the perineum for prevention of infection, irritation and to contribute to the resident's positive self-image." "Equipment [underscored] May include washcloth(s), disposable wipes, towel(s),	ILAKEVIEW MAN (X4) ID PREFIX TAG incontreside return washed the washed washed reside washed washed and th 5. Re p.m., to and un the for "Purpe perine irritati positiv "Equip washed peri-w	AND FLAN O	I CORRECTION		1		00		
LAKEVIEW MANOR INC LAKEVIEW MANOR INC SIMMARY STATEMENT OF DEFICIENCES (FACH DEFICIENCY MIST BE PERCEIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) incontinent briefs. CNA #14 exited the resident's room, entered the bathroom and returned to the bedside with two wet washcloths and a towel. CNA #16 took the washcloth from CNA #14 and washed the resident's lower abdomen in a back and forth motion and then dried the area with a towel. The CNA took the second washcloth and then dried the area. CNA #14 easisted in turning the resident to the right side and CNA #16 used the same washcloth, wiped the resident's buttocks and then dried the area. 5. Review of policy on 09-13-11 at 12:40 p.m., titled "PERINEAL CARE [bold type and underscored], dated 01-06, indicated the following: "Purpose [underscored]: to cleanse the perineum for prevention of infection, irritation and to contribute to the resident's positive self-image." "Equipment [underscored] May include washcloth(s), disposable wipes, towel(s),	ILAKEVIEW MAN (X4) ID PREFIX TAG incontreside return washed the washed washed reside washed washed and th 5. Re p.m., to and un the for "Purpe perine irritati positiv "Equip washed peri-w			1.000.1	B. WIN		DDDESS CITY STATE ZID CODE	00/10/2	
LAKEVIEW MANOR INC INDIANAPOLIS, IN46224 SUMMARY STATEMENT OF DEFICIENCIES PRETIX GEACH DEFICIENCY MUST BE PERCEDED BY PULL REQUIZIONEY OR LSC IDENTIFYING INFORMATION) incontinent briefs. CNA #14 exited the resident's room, entered the bathroom and returned to the bedside with two wet washcloths and a towel. CNA #16 took the resident's lower abdomen in a back and forth motion and then dried the area with a towel. The CNA took the second washcloth and repeated washing the resident's lower abdomen with the wetted washcloth, wiped the resident's buttocks and then dried the area. 5. Review of policy on 09-13-11 at 12:40 p.m., titled "PERINEAL CARE [bold type and underscored], dated 01-06, indicated the following: "Purpose [underscored]: to cleanse the perineum for prevention of infection, irritation and to contribute to the resident's positive self-image." "Equipment [underscored] May include washcloth(s), disposable wipes, towel(s),	incontreside return washed the washed washed and the followith for the followith for the followith a washed and the followith	NAME OF PR	OVIDER OR SUPPLIER			1			
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washcloth(s), disposable wipes, towel(s),	washe peri-w		"Equipment [und	erscored] May include					
	peri-w	I .							
peri-wash, soap product, wash basin,	1 ^								
gloves, bags for disposal of trash and	I gloves								
linens (if needed)."				-					
			- (
"Procedure [underscored]:	"Proce		"Procedure funde	erscored]:					
1. Obtain necessary equipment and take			=	_					

000032

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077		A. BUII	LDING	NSTRUCTION 00	(X3) DATE: COMPL	LETED	
		100077	B. WIN			09/16/2	.011
	PROVIDER OR SUPPLIER			45 BEA	DDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE APOLIS, IN46224		
				<u> </u>	AI OLIO, 11440224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	to resident's beds	side.					
		edure to resident and					
	provide privacy. Drape if needed.						
	1	ent - female resident may					
		pine position or in side					
		unable to adequately					
		from supine position due					
		oblems, contractures of					
		resistance to care.					
	4. Fill basin with						
	applicable, and have resident check water						
	temperature.						
	5. Apply gloves.						
	6. Assist residen	t to spread legs and lift					
	knees, if possible	2.					
	7. Remove dispo	osable brief or pad, if					
	applicable and pl	lace in trash bag.					
	8. Remove dirty	gloves and apply a clean					
	pair.						
	8. <sic> Wet and</sic>	soap washcloth, wet and					
	apply peri-wash	to washcloth obtain					
	disposable wipe.						
	9. If resident has	s a catheter, check for					
	leakage, secretion	ns or irritations. Gently					
	wipe approximat	ely four inches of					
	catheter from me	eatus out.					
	10. Wipe from f	ront to back and from					
	center of perineum to thighs. Change						
	cloth or wipe as	necessary."					
		Separate labia. Wash					
		t. b. Wash between and					
		lownward strokes,					
	alternating from	side to side and moving					

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		A. BUI	LDING	00	COMPL 09/16/2	ETED	
		1	B. WIN		DDRESS, CITY, STATE, ZIP CODE	1 - 5: 10:2	- · ·
NAME OF I	PROVIDER OR SUPPLIER				CHWAY DRIVE		
LAKEVIE	W MANOR INC				APOLIS, IN46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
		s. Use different part of		0			J.H.S
	is uncircumcised using circular mo urethra. b. Cont	Pull back foreskin if male . Wash and rinse the tip otion beginning at tinue washing down the tum and inner thighs."					
	washcloth: use n thoroughly in the washing. 12. Gently pat d as when washing 13. Assist reside from you. 14. Wet and soa wipe. 15. Clean anal a Rinse and pat dry	ent to turn onto side away p washcloth or obtain rea from front to back.					
	and assist resider undrape resident 17. Place dirty l 18. Remove glo 19. Wash hands Review of policy p.m., titled "Oral dated 09-05 indic	nt to turn onto back and , if needed. inens in bag. ves.					
		and to lessen the					

PRINTED: 10/11/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077			(X2) MULTIP A. BUILDING B. WING		OO	(X3) DATE S COMPL 09/16/2	ETED
	PROVIDER OR SUPPLIER		45	BEAC	DDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE APOLIS, IN46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			Έ	(X5) COMPLETION DATE
F0314	IN00095455 and 3.1-38(a)(3)(A)	relates to Complains IN00096396.					
F0314 SS=G			F0314		1. Treatment was secured at Resident J's care plan was reviewed and revised, as indicated, relative to the newlidentified open areas. Staff wimmediately re-educated as the prompt incontinence assistant and necessary measures to prevent development of presulcers. As all residents have the potential to be affected, the following corrective measures were implemented: As a means to ensure ongoing compliance with ensuring a resident is free from pressure ulcers, Nursing staff were re-educated on nurse aide assignment sheet use-	ly vere co nce sure ve he	10/07/2011

000032

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		(X2) MULTII A. BUILDIN B. WING		OO	(X3) DATE S COMPL 09/16/2	ETED	
	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DRIVE INDIANAPOLIS, IN46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	o9-08-11 at 10:3 assessed by the Wassessed by the Resident "J" included to schizophrenic disorder and den These diagnoses time of the record Review of the resident requirements and incomplete and inco	sident's Minimum Data dated 08-09-11, indicated ired total care for tion, dressing, eating, ontinent needs. In essment indicated the have a previous history of sident's plan of care, indicated the resident are with Activities of e total dependence for bed rs, eating and toilet use. an of care for Urinary ted 08-18-11, indicated incontinent of bladder			specifically as it relates to incontinence care and press ulcer prevention (see attachments I and J). The I or her designee will make ro twice daily on scheduled word days for 4 weeks, then twice weekly for 4 weeks, then we thereafter ensuring that residure provided incontinence can a timely manner and interver implemented per the plan of to prevent pressure ulcer development (see attachmental and corrective action taken, warranted. 4. As a means of quality assurance, the finding the above audits and any corrective actions taken will reviewed during the facility's quarterly Quality Assurance meetings and the plan of act revised, if warranted.5. The above corrective measures we completed on or before Octo 7, 2011.	DON unds rk ekly dents are in ations care of (gs of be) ion will be	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	155077			LDING	00	09/16/2	
		100077	B. WIN		ADDRESS STATE STATE STATE	03/10/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE		
LAKEVIE	W MANOR INC			1	APOLIS, IN46224		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		nt at least every two					
	hours and ask and or check for evidence						
	of incontinence."						
	Interventions to this plan of care included						
		assist resident with					
	_	sitioning at least every					
		ide incontinent care after					
	each incontinent						
		r					
	The plan of care,	dated 08-10-11, with the					
	identified proble	m "risk for the					
	development of p	oressure ulcers due to					
	incontinence, spe	ends all/lost of time in					
	bed/chair, impair	ed communication,					
	impaired cognition	on, and dependence on					
	staff for transfers	s, repositioning and bed					
	mobility. " Inter	ventions to this plan of					
	care included "ap	pply preventative topical					
	medication as or	dered - Xenaderm every					
	shift, provide inc	ontinence care after each					
	-	de, encourage and assist					
		ning and repositioning at					
	least every two h	ours."					
	During observati	on on 09-09-11 at 8:15					
	-	t was observed seated in					
	<i>'</i>	emained seated in the					
	wheelchair until						
	-	ade to check the resident					
		CNA- Employee #16					
		dent was "up and in the					
	wheelchair since	about 7:30 a.m." The					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPL 09/16/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			CHWAY DRIVE		
	EW MANOR INC			1	APOLIS, IN46224		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG			TAG	DEFICIENCE)		DATE	
	1 ^	vn the front of the					
	1	and indicated the resident					
	1	quest was made to transfer bed to check skin.					
	1	ees #14 and #16 exited the					
	minutes later ret	and approximately 10					
	1	urned with the					
	mechanical lift.						
	The CNA's posi-	tioned the lift in front of					
	1	fastened the appropriate					
		ling that was already					
		ath the resident, and then					
	1 ^	esident to bed. The					
		the resident's slacks,					
		ncontinent brief, and a					
	1	urine permeated the air.					
		s wearing one incontinent are other and the inner brief					
		d heavy with urine. The					
	resident had bee	they were unaware the					
	incontinent brief	-					
	incontinent orien	15.					
	During observat	ion on 09-14-11 at 9:30					
	_	t was observed lying					
	•	back) in bed. Further					
	1 * `	9-14-11 at 12:00 p.m.,					
		ained in the supine					
		est was made to check					
	the resident for i	ncontinence. The					
	Licensed Practical Nurse-Employee #26						
	pulled the bed li	nens down to the end of					
	the bed, looked	at the brief and indicated					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		A. BUILDIN B. WING		00	COMPL 09/16/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DRIVE INDIANAPOLIS, IN46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	Ē	(X5) COMPLETION DATE	
	made to turn the resident's skin. I Employee #26 er Licensed Practica and both turned to side. The incontrunfastened and the with two incontructions was turned to the were observed. If #27 verified the and measured earlight buttocks me "around and 0.2 of in length, while a buttocks/coccyx"	"dry." A request was resident and check the Licensed Practical Nurse-alisted the assistance of al Nurse-Employee #27, the resident to the left inence brief was the resident was observed then briefs on. The inner the urine. As the resident to left side, two open areas Licensed nurse-Employee areas were pressure areas the one. Area #1 on the reasured 1 cm [centimeter] tem. in width by 0.8 cm. area #2 located on the left measured 0.1 centimeter cm in width by .4 cm in						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155077	B. WIN			09/16/2	011
			В. WПV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	CHWAY DRIVE		
I AKFVIF	W MANOR INC			l	APOLIS, IN46224		
				<u> </u>			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE
F0323	-	nsure that the resident ins as free of accident					
SS=D							
	hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and						
			F0	323	Resident E no longer resident		10/07/2011
		cility failed to ensure the			at the facility. Resident G 's	-	
		ts, in that when residents			of care was reviewed and rev	vised	
		Falls, which included a			to ensure history of falls and applicable interventions are		
	_	ing staff failed to ensure			addressed. 2. As all resider	nts at	
		nd implementation of			risk for falls have the potentia		
	*	*			be affected, the following		
	assist devices to				corrective actions were taker		
		ers for 2 of 5 residents			As a means to ensure ongoir	-	
	reviewed for falls	s in a sample of 10.			compliance with ensuring the		
	[Residents "E" an	nd "G"].			safety of residents with a history of falls, Nursing staff were		
					re-educated on the Gait Belt		
	Findings include	<u>.</u>			policy and procedure and the		
	_				Management Program (see		
	1 The record for	r Resident "E" was			attachments M & N). The DO	NC	
		13-11 at 3:00 p.m.			or her designee will review a		
		led but were not limited			new admissions within 24 ho	urs	
	-				of admission to ensure that		
		ir with open reduction			should fall risk be identified, a appropriate intervention was	an	
		tion, hypertension,			implemented and reflected or	n the	
	, ,	, and vertigo. These			plan of care (see attachmen		
	diagnoses remain	ned current at the time of			Additionally, the DON or her	,	
	the record review	<i>V</i> .			designee will make		
					observations/rounds twice da	•	
	Review of the ho	spital notations, which			on scheduled work days for		
		ultation note - final			weeks, then twice weekly for weeks, then weekly thereafte		
		-15-11, indicated family			ensuring that residents fall	, 10	
	• .	ned with the physician			interventions are implemente	ed	
					per the plan of care, including		
	the resident had "multiple falls lately." An additional notation indicated the				leaving a fall risk resident on		
					toilet unsupervised and utilizi	ing	
	resident had "syn	scope with falls."			gait belts with transfers (see		
					attachment K). Should cond	erns	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		A. BUILI	DING	NSTRUCTION 00	(X3) DATE S COMPL 09/16/2	ETED	
		111011	B. WING		DDRESS, CITY, STATE, ZIP CODE	55.15.2	
NAME OF I	PROVIDER OR SUPPLIEF	8			CHWAY DRIVE		
	W MANOR INC			INDIANA	APOLIS, IN46224		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	`		P		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	
PREFIX TAG	REGULATORY OR The hospital "Ac and physical] Fin addendum," and an assessment the frequent falls and yr. [year] with indescribes both splight-headedness light-headedness falls secondary to light-headedness hip fracture." The "Admission dated 05-23-11, staff regarding "assist of 2." The the facility in ord therapy and occurrent documentation, a resident's chart in alert and orienter forgetfulness, fel with a family memultiple falls, very of a walker and at the Initial Care identified the residentified the resident and physical properties.	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) Imission H & P [history hal Report, with dated 05-13-11, included at [family and pt. indicate d syncope over the past hereasing frequency. Pt. binning and d, but today it was deprimarily. History of to deficit and Plan of Care, hinstructed the nursing frequency with the resident was admitted to der to receive physical hipational therapy. It notification" frixed to the front of the midicated the resident was d with minor deficits and ll outside while walking member, had a history of ertigo and required the use	P	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ns . As e, the and will y's	COMPLETION DATE
		ed safety awareness and ventions to these					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155077	A. BUII		00	09/16/2	
		100077	B. WIN		ADDRESS CITY STATE TIN CODE	03/10/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE		
LAKEVIE	EW MANOR INC			1	APOLIS, IN46224		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	JΈ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1 *	ms included "assess and					
	1	light within reach,					
	1 ^ ^	lighting, assure proper					
		ar and keep walkway					
	clutter free."						
	The gubes	para plan also data l					
		care plan, also dated dentified the resident					
		sk factor for falls, such as					
	1 ^						
	1	onfusion and pain."					
		luded "provide adequate pathways are clutter free,					
	1 0 0, 1	e foot wear with non-skin					
	<sic> soles, mon</sic>						
	1 ^ -	the call lights are not					
	· ·	ning room, activities,					
		fall risk assessment upon					
	· · ·	erly and with any					
	-	ge, monitor vital signs as					
	indicated, neurol	•					
		responsible party and					
		octor] if a fall occurs,					
	1	Implement interventions					
		falls: (list interventions					
		l), 05-23-11 PT/OT eval					
		assist with ADL's					
	⁻	y living], 05-26-11 bed					
	alarm."						
	Review of the 5 of	day Minimum Data Set					
		d 05-30-11, indicated the					
	1	extensive assistance					
	1 ^	y, transfer and toileting,					
		o "steady self only with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 09/16/2	ETED	
	PROVIDER OR SUPPLIEF	! }		STREET A	DDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE APOLIS, IN46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	from surface to s seated position to The assessment frequently incon occasionally inco	e in regard to moving surface or moving from a o a standing position. indicated the resident was tinent of urine and ontinent of bowel.					
	The fall risk assessment, dated 05-24-11, indicated the resident had a "history of falls, used assist devices, had confusion, weakness, poor vision, an unsteady gait, and use medications which included narcotics, antihypertensives and diuretics.						
	The Physical Therapy Evaluation, dated 05-24-11, indicated the resident was "non-ambulatory at this time" and at "risk for falls." In addition the evaluation indicated the resident was "alert" but "confused" and required maximum assist with changing positions from a lying position to standing, sitting to standing, bed to wheelchair and had "poor" balance with sitting and standing.						
	Evaluation, date	ccupational Therapy d 05-24-11, indicated the awareness" was					
	specialist, dated resident was "res	om the mental health 05-25-11, indicated the ferred to psychology oor adjustment to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		(X2) MULT A. BUILDI B. WING		00	(X3) DATE: COMPL 09/16/2	ETED	
	PROVIDER OR SUPPLIER		S 2	45 BEAC	DDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE APOLIS, IN46224	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	mental status. C symptoms] inclu hallucinations and auditory hall seeing portraits of and that they followink at her, smill long hx of mental aware that halluce events." Review of the nut following: "05-23-11 at 7:10 admitted from [n hospital] alert time or place, grimove right leg distaple in right hij up by self" "05-24-11 4:15 at to name, confuse "05-26-11 at 5:00 found sitting on stated she was at bed per self. 2.2 cm abrasion note."	ession, anxiety, ing and recent altered urrent s/s [signs and de auditory/visual pt. reports both visual ucinations. pt reports of men's faces on her wall low her with their eyes, e etc. Per staff, pt. has a all health issues. Pt. seems cinations are not real urses notes indicated the p.m. Pt. [patient] ame of local area to self, does not know ips weak. Pt. unable to ue to fx. [fracture]. pt. has p, unable to stand or sit a.m. arouse easily - alert and to time and place." p. a.m., "Res. [resident] floor next to bed. res. tempting to get out of cm [centimeter] by 2.8 and to left mid back." p. cial Service Assessment, indicated the resident					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077		A. BUILDING		NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		45	BEAG	DDRESS, CITY, STATE, ZIP CODE CHWAY DRIVE APOLIS, IN46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	conveyed to the substance of the substan	staff member of he last several days, with sudden movement. at home to right side. altiple falls recently. d right hip fracture. k. [history] of mental h visual hallucinations					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155077	B. WIN			09/16/2	011
		<u> </u>	P		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	S.			CHWAY DRIVE		
LAKEVIE	W MANOR INC				APOLIS, IN46224		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	, -		(X5)
PREFIX				PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110	the record review.			1110			Ditte
	l life record review	v.					
	D : C4 M	· · · · · · · · · · · · · · · · · · ·					
	Review of the M						
		d 06-16-11, indicated the					
		extensive assistance					
		ed mobility and transfers.					
	The resident was	also assessed with					
	incontinency of a	arine.					
	-						
	The resident's ca	re plan, dated 06-17-11,					
		ident was "at risk for					
		tervention indicated "non					
	skid strips in bath						
	SKIU SUIPS III Dau	moom.					
	A plan of care d	ated 06-17-11, indicated					
	1 *	uired up to extensive					
	1 ^	•					
	1 ^	ing ADL's due to					
	_	pain to lateral knees and					
	unsteady balance	2."					
		. 1 . 102.22					
		essment, dated 06-22-11,					
		ident had a history of					
	falls, required the	e use of an assist device,					
	had confusion, w	eakness and an unsteady					
	gait.	•					
	The physician pr	ogress notes, dated					
		ted the resident had lower					
	extremity edema, with family concern that						
	the resident is not on any diuretic.						
	uic iesident is no	on on any united.					
	During on interes	iow on 00 00 11 of 9.20					
	· -	iew on 09-09-11 at 8:30					
	a.m., a concerned	-					
	indicated recentl	y when the family					

		IDENTIFICATION NUMBER: A. BU		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED 09/16/2011	
l l								
		155077	B. WIN			09/16/2	011	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
LAKENEM MANOR INO			45 BEACHWAY DRIVE					
LAKEVIEW MANOR INC			INDIANAPOLIS, IN46224					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
IAU	REGULATORY OR LSC IDENTIFYING INFORMATION)		-	IAG	BEI TELEXOT)		DATE	
	member arrived at the facility, the resident							
	was found seated on the side of the bed,							
	without anyone helping [name of							
	resident]. "[name of resident] could have							
	fallen, where was the staff and how could							
	they have left [resident] alone like that? I							
	1 ^	dministrator about it and						
	, ,	of my mind. I know it						
	better never happ	oen again."						
	_	vation on 09-13-11 at						
	1 * '	[A [Certified Nurse Aide]						
		ileted the resident. The						
	1	pelt attached to he own						
	waist and not the	resident. The resident						
	was observed sea	ated on the commode						
	with the walker a	adjacent to the commode.						
	The CNA, witho	ut saying anything, left						
	the bathroom wh	ile resident remained on						
	the commode.	The CNA returned to the						
	resident's room c	arrying a towel and two						
	washcloths. The	CNA performed pericare						
	adjusted the resid	dent's clothing and						
	instructed the res	ident to stand up. With						
	difficulty, the res	sident stood and the CNA						
	moved the reside	ent from in front of the						
	commode to a w	heelchair without the use						
	of a gaitbelt.							
	3. Review of the	facility policy on						
		0 a.m., and titled "Gait						
		dated 09-05 indicated the						
	following:							
	_	d type]: To insure <sic></sic>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 00		(X3) DATE SURVEY COMPLETED	
		155077	A. BUILDING B. WING		 09/16/	09/16/2011	
NAME OF PROVIDER OR SUPPLIER			45 E	EET ADDRESS, CITY, STATE, ZIF BEACHWAY DRIVE	CODE		
LAKEVIEW MANOR INC			IND	IANAPOLIS, IN46224			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
	safety in transfer provide a point of support from the to staff and resid transfer or ambut. 4. Review of the 9:40 a.m., titled Procedure," and following: "PURPOSE [bol residents for risk contribute to fall interventions ide appropriate, for maintaining or relevel of physical functioning as possible." "PROCEDURE the fall risk assess upon admission, and with signific The interdiscipling team will review determine if furth 3. The interdiscipling team will determine of falls and/or in the staff and the safety and the safety and the safety are most appropriate and the safety and the safety are most appropriate and safety	and ambulation. To if contact and increased staff and prevent injuries ent's who are unable to late independently." e policy on 09-14-11 at 'Fall Management dated 02-05, indicated the d type] To assess all factors that may ing. To provide planned ntified by the team, as resident use in eturning to the highest social and psychosocial					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077	(X2) MULTIPLE CO A. BUILDING B. WING	00		E SURVEY PLETED /2011		
NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR INC			STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DRIVE INDIANAPOLIS, IN46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE		
	3.1-45(a)(2)							